Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN SPECIALTY HOSPITAL
300 KINGWOOD MEDICAL DR
KINGWOOD TX 77339-6400

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-11-3294-01

MFDR Date Received
May 27, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Hartford submitted an underpayment of $7,638.82 to the facility. This was not according to the Texas Workers' Compensation Fee Schedule, so a 1st level appeal was mailed on 04/26/2011 and an additional payment of $203.23 was made on 05/11/2011. To date we are still underpaid by the carrier in the amount of $7,842.08."

Amount in Dispute: $10,517.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the policy governing device intensive procedures, the carrier has made payment for the service portion of the APC multiplied by 200% with an additional payment of the device cost pursuant to Texas Guidelines. . . . Based on this policy, the carrier contends that provider has been fully compensated for this service and is not entitled to additional reimbursement."

Response Submitted by: The Hartford, 300 South State Street, Syracuse, New York, 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2011	Outpatient Hospital Services	$10,517.80	$10,483.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 217 – THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY QMEDTRIX'S BILLCHEK SERVICE. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PACKAGED SERVICES ARE INCLUDED IN THE APC RATE.
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. REIMBURSEMENT BASED ON QMEDTRIX CORRECTION
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. REIMBURSEMENT FOR YOUR NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO STATE FEE GUIDELINES OR RULES AND REGULATIONS.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. REIMBURSEMENT BASED ON QMEDTRIX CORRECTION." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. The respondent's position statement asserts that "Policies regarding device intensive procedures has been discussed and referenced in the TDI/DWI § 134.402 rules and comments." Review of the Texas Department of State Health Services records finds that the health care provider is licensed as a general hospital, not as an ambulatory surgical center; therefore, the *Ambulatory Surgical Center Fee Guideline* at 28 Texas Administrative Code §134.402 is not applicable to the services in dispute. The Division finds that this dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of the *Hospital Facility Fee Guideline — Outpatient*, at 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 63650 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,731.81. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $2,705.04. The non-labor related portion is 40% of the APC rate or $1,821.21. The sum of the labor and non-labor related amounts is $4,526.25. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.191. This ratio multiplied by the billed charge of $14,962.00 yields a cost of $2,857.74. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $4,526.25 divided by the sum of all APC payments is 49.40%. The sum of all packaged costs is $808.15. The

allocated portion of packaged costs is $399.21. This amount added to the service cost yields a total cost of $3,256.95. The cost of this service exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service is $4,526.25. This amount multiplied by 200% yields a MAR of $9,052.50.

- Procedure code 63650-59 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,731.81. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $2,705.04. The non-labor related portion is 40% of the APC rate or $1,821.21. The sum of the labor and non-labor related amounts is $4,526.25. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $4,526.25. This amount multiplied by 200% yields a MAR of $9,052.50.
- Procedure code 95972 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0692, which, per OPPS Addendum A, has a payment rate of $110.95. This amount multiplied by 60% yields an unadjusted labor-related amount of $66.57. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $65.92. The non-labor related portion is 40% of the APC rate or $44.38. The sum of the labor and non-labor related amounts is $110.30. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $110.30. This amount multiplied by 200% yields a MAR of $220.60.
- Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $18,325.60. This amount less the amount previously paid by the insurance carrier of $7,842.08 leaves an amount due to the requestor of $10,483.52. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10,483.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10,483.52, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 4, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.